TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Sports Ortho Surgery Center LLC

Respondent Name
TASB Risk Management Fund

MFDR Tracking Number
M4-23-3329-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
August 29, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 2, 2023	29880	$4109.48	$0.00
August 2, 2023	29879	$2054.74	$0.00
	Total	$6164.22	$0.00

Requestor's Position

"...According to your TDI ASC fee guidelines for our facility we should get reimbursed 235% x our Medicare fee schedule for our locality which is Texas, attached is a copy of what Medicare allows for the codes billed. A dispute form, Medicare fee schedule, authorization, and TASB explanation of benefits is attached for your review convenience."

Amount in Dispute: $6164.22

Respondent's Position

"This request will be standing on the previous allowance of $4,526.63 as the charges were paid at the correct Ambulatory Surgery Center markup of 235%."

Response submitted by: TASB Risk Fund

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.402 sets out the fee guidelines for ambulatory surgical centers.

Denial Reasons

The insurance carrier reduced the payment for the disputed services with the following claim adjustment codes:

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 350 – Bill has been identified as a request for reconsideration or appeal.
- 59 – Processed based on multiple or concurrent procedure rules.
- 615 – Payment for this service has been reduced according to the Medicare multiple surgery guidelines.
- 662 – Separate payment for this service is not warranted as the service is an integral part of the surgical procedure package.
- 790 – This charge was reimbursed in accordance to the Texas Medical fee guideline.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. Are the insurance carrier's reductions supported?

2. Is requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional payment for a surgery rendered in an ambulatory surgical center on August 2, 2023. The insurance carrier reduced the payment based on the Medicare multiple procedure payment policy and the workers' compensation fee guideline. The maximum allowable reimbursement of the disputed services is calculated below per applicable fee guideline.

2. DWC Rule 28 TAC §134.402 (d) requires Texas workers' compensation system participants when coding, billing, reporting and reimbursement to apply Medicare payment policies in effect on the date of service.

The Medicare payment policy applicable to the services in dispute is found at www.cms.gov, Claims processing Manual, Chapter 4, Section 10.1.2 specifically Ambulatory Surgical Center Services on ASC list. Beginning with the implementation of the 2008 revised payment system, the labor related adjustments to the ASC payment rates are based on the Core-Based Statistical Area (CBSA) methodology. Payment rates for most services are geographically adjusted using the pre-reclassification wage index values that CMS uses to pay non-acute providers. The adjustment for geographic wage variation will be made based on a 50 percent labor related share.

DWC Rule 28 TAC §134.402 (f) states in pertinent part the reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the Federal Register.

Procedure Code 29880 has a payment indicator of A2. DWC Rule 28 TAC 134.402 (f) (2) states in pertinent part reimbursement for non-device intensive procedures shall be the Medicare ASC facility reimbursement amount multiplied by 235 percent. The following formula was used to calculate the MAR:

- The Medicare ASC reimbursement for code 29880 for applicable date of service is $1,414.73.
- The Medicare ASC reimbursement is divided by 2 = $707.36.
- This number multiplied by the CBSA for Harlingen, Texas of 0.8154 = $576.78.
- Add these two together = $1284.14.
- To determine the MAR, multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235% = $3,017.74.

Procedure Code 29879 has a payment indicator of A2. This procedure is subject to multiple procedure discount. The MAR will be reduced by 50%. DWC Rule 28 TAC 134.402 (f) (2) states in pertinent part reimbursement for non-device intensive procedures shall be the Medicare ASC facility reimbursement amount multiplied by 235 percent. The following formula was used to calculate the MAR:

- The Medicare ASC reimbursement for code 29880 for applicable date of service is $1,414.73.
- The Medicare ASC reimbursement is divided by 2 = $707.36.
- This number multiplied by the CBSA for Harlingen, Texas of 0.8154 = $576.78.

- Add these two together = $1284.14.
- To determine the MAR, multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235% = $3,017.74 divided by 50% = $1,508.87.

3. The DWC finds the MAR for disputed services is $4,526.61. The respondent paid $4,526.63. No additional payment is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		October 6, 2023
Signature	Medical Fee Dispute Resolution Officer	Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3, or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.